

EXHIBIT II

BURL

Labor Market Areas Used in Calculating Equalization Factors

<u>Area</u>	<u>Abbreviation</u>	<u>Counties Included</u>
1.	PASSA	Passaic
2.	HACK	Bergen
3.	NEWT	Sussex, Warren
4.	TRENT	Mercer, Hunterdon
5.	NEWARK	Union, Essex, Somerset, Morris
6.	JERCIT	Hudson
7.	NEBRU	Middlesex
8.	LBRAN	Monmouth, Ocean
9.	ATCIT	Atlantic, Cape May
10.	CAM/BURL	Burlington, Camden, Gloucester, Salem, Cumberland

83-7

OFFICIAL

1983 HOSPITAL RATE REVIEW GUIDELINES

Supersedes 81-14
Approved 10/6/83
Effective 1/1/83

11

OFFICIAL

83-7

Objectives of the Hospital Rate Review Program

The rate review program is charged with establishing reimbursement rates for hospitals which reflect reasonable costs for the health care facilities involved.

The two basic principles upon which the Guidelines are formulated are that the Department shall establish that for each hospital:

1. The costs currently incurred are reasonable for the level of services currently provided and
2. Any increases in those costs are reasonable.

The methodology is formulated in accordance with these principles.

For the year 1983¹ for specialized and rehabilitation hospitals not covered under N.J.A.C. 8:31B-1 et seq. in the State of New Jersey, it is the Department's objective to limit the average increase in hospital inpatient expenditures (both cost and volume) which are reimbursed by hospital service corporations, the State's medical assistance program, and other covered governmental agencies, referred to hereafter as "payors," to a maximum of one and one-half percent (1.5%) above the Department's established Economic Factor.

¹ All year numbers in this rule will automatically increase by one beginning January 1, 1984.

[REDACTED]

Rules Concerning 1983 Hospital Rate Review Guidelines

Allen N. Koplin, Acting Commissioner of Health, pursuant to the authority of N.J.S.A. 26:2H-1, et seq. N.J.S.A. 17:2H-1 et seq. and with the approval of Health Care Administration Board, adopts the following rules concerning the 1983 rate review for hospitals.

1. Authority

In accordance with N.J.S.A. 26:2H-1 et seq., payment by hospital service corporations and government agencies for health care services provided by a hospital shall be at rates approved as to reasonableness by the Commissioner of Health taking into consideration the total costs of the hospital.

2. Scope of Rules

Unless otherwise provided by rule or statute, the following shall constitute the rules of practice and procedure for determining hospital payment rates relative to 1983 admissions only, and for appeals from an administrative rate determination.

In accordance with N.J.S.A. 26:2H-18, the elements of cost will be those defined by the Commissioner of Health.

3. Definitions

In addition to those definitions outlined in N.J.A.C. 8:3-1.4, the following definitions shall apply:

- A. "Director" is the Director of Health Economics Services.
- B. "Analyst" is the Analyst, Health Economics Services, to whom an individual hospital's cost submission has been assigned.
- C. "Payors" are hospital service corporations and government agencies that are contractual purchasers of health care services.
- D. "Approved Rate" is the current rate in effect established by the Rate Review Program. The approved rate provides reasonable reimbursement for covered inpatient hospital costs. Costs which are attributed to non-eligible or outpatient services are not reviewed and are not part of the approved reimbursement rate under the SHARE Program.
- E. "Global Rate" is the Final Administrative Payment Rate for 1983 determined by adjusting the 1982 Global Budget by an increment, as described in Section 5.A. below.
- F. "Alternate Rate" is the 1983 rate determined by applying these rate review guidelines to the lower of the 1981 actual costs or 1981 approved costs, as described in Section 6 and all subsequent sections below.

7. For each cost center where non-physician services are being rebundled, a complete breakout of the 1982 base year costs will be required. This is being requested so as to ensure that the rebundled items are not in the 1982 base. Subsequently, verification that the rebundled items are not in the base will be provided to the third-party payers, by the Department.

The review to be performed by the hospital rate analysts and the HRSC is as follows:

1. The rate analyst will ensure that the rebundled services are not in the base. The analyst will need to scrutinize the cost information provided to the Department by the hospital. This, in some cases, may require further documentation from the hospital. This verification will occur during the appeals process.
2. The charges (as provided by the hospital) for the rebundled services, will be compared against Medicare's 1983 charge data provided by the fiscal intermediaries. The hospital will be allowed the lower of its own charges or the 75th percentile of Medicare's prevailing rate. This calculation will be performed at Final Reconciliation with the disincentive being part of the over/(under)collection at year end. It will be treated as an indirect adjustment, similar to MICU's and CAT Scans.

EXAMPLE:

REV. CODE	REBUNDLED SERV.	HOSP. COST	MEDICARE PREVAILING CHARGE	DISIN- CENTIVE	# OF PRO- CEDURES	TOTAL
1.7883	CAT Scan	250	300	0	10	0
2.7519	Digital Angiogram	400	350	50	5	250
						\$250

3. The Department will provide, to the payers and the HRSC, a list of the approved rebundled services as soon as this list can be compiled.

This methodology will ensure that the hospital receives an equitable payment rate for the rebundled services and that the rate for payers is reasonable.

OFFICIAL

4.19-A

ATTACHMENT 4.19-A

STATE PLAN UNDER TITLE XIX
of the SOCIAL SECURITY ACT

Reimbursement for Inpatient Hospitalization -

ALLOWABLE COSTS

Allowable costs are those defined by the Title XVIII
principles of reimbursement excluding the nursing salary
cost differential as per 42 CFR 447.261(c)(1).

ST. 718 SA Approved 6/30/80
Effective 1/1/80 RO Approved 7/29/80

80-18-MA(HJ)

15-27

NJ 80-18

Medicaid Inpatient Hospital Cost Settlement Procedure

The SHARE system is designed to conform with the Blue Cross contract cost principles. There are substantial differences in the cost principles between the Blue Cross contract and SHARE system and the Medicare Cost Principles. The Program bridges the difference between the two systems by the final settlement process. The prospective SHARE rates established for Medicaid are used for interim payments. The SHARE Final Payment Rate for Blue Cross is used as a capping mechanism to determine reasonable costs from the audited Medicare cost reports, Form SSA-2552. The following is a step-by-step explanation of this process:

1. The inpatient cost apportioned to Title XIX from Form SSA-2552 or 2551, Worksheet E-5, Part III, Line 3 is reviewed to determine if there are any Medicare limitations.

1a. If no limitations exist, the process begins with this amount.

1b. If there are limitations, the amount apportioned to Title XIX prior to the limitation is used. This is because the hospital may incur a SHARE limitation which in addition to a Medicare limitation would be analogous to a "double jeopardy" situation. This will be seen after review of the following steps.

2. Determine the approved per diem and the audited per diem for Blue Cross reimbursement from Form HES 4a, prepared by the Department of Health (lines M and L respectively).

3. Determine the allowable Blue Cross costs and the Blue Cross ceiling cost by multiplying the number of Blue Cross patient days by the allowable Blue Cross rate and the Blue Cross ceiling rate, respectively.

4. Determine the Medicaid Allowable Cost from Form SSA-2552 or 2551:

4a. From Worksheet C, Column 3, Line 29a, determine the Ancillary Cost.

4b. From Worksheet D-1, Part II, Line 35, determine the Allowable Inpatient Routine Costs.

4c. From Worksheet D-1, Part II, Line 43, determine the Allowable Nursery Costs.

4d. Determine the Hospital Based Physicians costs by multiplying the ratio of inpatient charges to total charges (from Worksheet C) by the Radiology, Pathology, Emergency Room and any other physicians costs on Worksheet D-3, Column 1.

date approved - July 29, 1980
effective date - January 1, 1980

14-18
~~89-81 MA~~ (NJ)

- 4e. Determine the cost of Interns and Residents from Worksheet D-2.
- 4f. Determine any other allowable costs from appropriate forms i.e., Renal Dialysis, Return on Equity Capital, etc.
5. Sum the amounts from Steps 4a through 4f above to determine the total allowable costs.
6. Determine the allowable cost ceiling by dividing the Blue Cross Approved Costs by the Blue Cross Certified Costs and multiplying this by the total allowable costs from Step 5 above.
7. Subtract the allowable cost from Step 6 above from total allowable costs to determine total excess costs.
8. Determine the Medicaid Inpatient Reimbursable Cost portion of total allowable costs by dividing the Medicaid Inpatient Costs from Worksheet E-5 by total allowable costs.
9. Multiply the resultant percentage from Step 8 above by the excess cost from Step 7 above to determine the Medicaid portion of excess costs.
10. Subtract the greater of the excess costs or the eligible charge limitation from Worksheet E-5, Part II, Line 17 to determine Medicaid Allowable Inpatient Costs.

3/27/79

JHH:er

date approved - July 29, 1980
effective date - January 1, 1980

50-29~~79-21-MA~~ (NJ)

SERVICES PROGRAM - TITLE XIX

FINAL SETTLEMENT WORKSHEET

NJ 80-18

PROVIDER NAME: _____ PROVIDER NO. _____

PERIOD FROM _____ TO _____

CLAIMS PAID FROM _____ TO _____

PREPARED BY _____ DATE _____

FINAL SETTLEMENT BASED ON 19 75 COMMISSIONERS' APPROVED RATE

I. In-Patient Reimbursable Cost: Level I Appeal

In-Patients Cost apportioned to Title XIX (W/S E-5 Pt. III Line 3) \$ _____

Carryover: Unreimbursable Charge Limitation for Prior Year
(W/S E-5 Pt. III, Line 6) _____

Less: The Greater of:

(a) Eligible charge limitation (W/S E-5 Pt. II Line 17) \$ _____

(b) Excess cost resulting from limitation imposed by
Commissioner _____

Inpatient reimbursable cost allowed under Program _____

Amount Paid by Contractor

Voucher Payments \$ _____

Interim Rate Adj. _____

Retro: _____

Other _____

Total Payments by contractors _____

Final settlement: Balance Due Hospital (Plan) \$ _____

II. Out-patient Reimbursable Cost:

Out-patient cost apportioned to Title XIX (W/S DLine 30) \$ _____

Out-Patient Program charges (total charges: settlement data) \$ _____

Out-Patient Reimbursement-The lower of cost or charges \$ _____

Less amounts paid by Contractor: Voucher Payments _____

Final Settlement: Balance Due Hospital (Plan) \$ _____

Net Inpatient/Outpatient Final Settlement \$ _____

date approved - July 29, 1980

effective date - January 1, 1980

17 - 30

79-21-MA (NJ)

³¹
Pages IV-28 through IV-35

Intentionally left blank

OFFICIAL

88-29(d)MA

TN 88-290 Approval Date JUN 30 1988
Supersedes TN **New** Effective Date 7-1-88